## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
		152007		A. BUILDING B. WING			011
		II .	D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER	t		ı	/ 10TH ST		
KINDREI	D HOSPITAL INDIA	NAPOLIS		1	APOLIS, IN46222		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	N SHOULD BE COMPLE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0000							
	This visit was fo	r a standard licensure	S0	000			
	survey.						
	-						
	Facility Number	. 006106					
	1 donney 1 (dilloor	. 000100					
	Survey Date: 7-	11/13_11					
	Survey Date: 7-11/13-11						
	Camararama						
	Surveyors:						
	Jack I. Cohen, M						
	Medical Surveyo	or					
	John Lee, RN						
	Public Health Nu	arse Surveyor					
		-					
	Albert Daeger						
	Medical Surveyor						
	ivicuicai surveyo	<i>)</i> 1					
		<b>-</b> 100111					
	QA: claughlin 0	7/29/11					
			1				1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

006106

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	
		IDENTIFICATION NUMBER: 152007	A. BUILDING		00	COMPLETED 07/13/2011	
		132007	B. WIN		DDDEGG GITTY GTATE ZID GODE	0771372	011
NAME OF PROVIDER OR SUPPLIER				l	ADDRESS, CITY, STATE, ZIP CODE  ' 10TH ST		
KINDREI	O HOSPITAL INDIAI	NAPOLIS		l	APOLIS, IN46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	410 IAC 15-1.4-1(	· · · · · · · · · · · · · · · · · · ·	-	TAG	DLI ICILI (C.1.)		DATE
S0320	4101/1010-1:4-1(	C)(U)(U)					
	<ul><li>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</li><li>(6) Require that the chief executive officer develops policies and programs</li></ul>						
	and a post offer phenomenation in consultation with control committee.		50	320	S320		08/26/2011
	Based on document review and interview,		50	320	3320		08/26/2011
	the facility failed policy/procedure				Immediate Corrective Action:		
		physical examinations			Our Employee Health Program has been revised to include Employee Health Nurse providing		
		ing personnel files					
		£1, E2, E3, E4, E5, E6,		History screening questionnaire to			
	E7, E8, 2, 3 and 4				new hires.		
	Findings include				Further Corrective Action to prevent Recurrence: All new hire information will be	oe	
	1. Review of policy/procedure H-IC				reported through the Infection Control Committee and any issues		
	05-001, Employe	ee Health Program,			identified with new hires will b		
	indicated the foll	owing: "2. Prospective			reviewed.		
	and current employees will undergo				Monitoring		
	periodic health e	valuations as required by			Monitoring: The Infection Control Committee will oversee		
	local and State lie	censure regulations.					
		de, but are not limited to	,		our Employee Health Program.		
	_	e following as described			Any issues identified will be Reported through Infection		
	by State or Feder	_			Control Committee meetings,		
	•	history or physical (this			Quality Council, MEC and Governing Board.		
	_						
	may be by a pers	onal physician, facility					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		152007	B. WING		07/13/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
עוגוסטרי		NADOLIE		N 10TH ST	
	D HOSPITAL INDIAI			NAPOLIS, IN46222	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		or facility's preferred		Responsibility:	
	provider)."	or ruently s preferred		Employee Health Nurse in	
	This policy/proce	edure was last		conjunction with Infection Control Program Director	
	reviewed/revised				
	2. Review of emp	ployee #E1, E2, E3, E4,			
	E5, E6, E7, E8, 2	2, 3 and 4's personnel			
	files indicated that	at each had a			
	pre-employment	history and physical			
	completed by sta	ff #47, a licensed			
	practical nurse.				
	3. On 7-13-2011	at 1445 hours, staff #40			
	confirmed that st	aff #47 does the			
pre-employment history and physicals.					
C1110	410 IAC 15-1.5-8 (	(h)(2)			
S1118					
	(b) The condition of				
	plant and the over environment shall				
		n a manner that the			
	safety and well-be				
	assured as follows	<b>3</b> :			
	(2) No condition s				
	maintained which				
	hazard to patients employees.	, public, or			
		ation, the hospital created	S1118	S1118	07/13/2011
		resulted in a hazard to	1		
	patients, public o	or employees in 5		Immediate Corrective Action:	
	instances.			All fire extinguishers were immediately placed in approp	riate
				holder.	
	Findings:				
				Further Corrective Action to	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	QKT11 Facility	y ID: 006106 If continuation s	heet Page 3 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		152007	B. WING		07/13/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		I	/ 10TH ST	
KINDREI	O HOSPITAL INDIAI	NAPOLIS	<b>I</b>	IAPOLIS, IN46222	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				prevent Recurrence:	
	1 On 7 11 11 of	12.20 mm in the		Director of Plant Operations	
	1. On 7-11-11 at	_		has reviewed with vendor	
	presence of empl			the importance of ensuring	
	observed in the N	Maintenance area that		fire extinguishers are placed	
	there were 5 fire	extinguishers on the		in appropriate holder	
	floor unsecured b	by chain or holder.			
		•		Monitoring:	
	2 If any of the a	bove extinguishers were		The Director of Plant	
				Operations will ensure	
		d broke the head off the		fire extinguishers are placed	
	1 2	nder, it could result in		in proper holder following	
	harm to people a	nd/or property.		each fire extinguisher	
				Maintenance. Any issues	
				identified will be corrected	.h
				on the spot and reported throug EOC, Quality Council, MEC	П
				and Governing Board.	
				Responsibility:	
				Director Plant Operations	
S1162	410 IAC 15-1.5-8(	d)(2)(A)		Birodor Flank operations	
	(d) The equipment	t requirements are as			
follows:		roquiromonio aro do			
	(2) There shall be	sufficient			
	equipment and spa				
	safe, effective, and	d timely provision			
	of the available se	rvices to patients,			
	as follows:				
	(A) All mechanica	l equipment			
	(pneumatic, electri				
• · · · · · · · · · · · · · · · · · · ·		ed maintenance			
		priate frequency and			
		urer's recommended			
	maintenance sche				
	Based on docume	ent review and interview,	S1162	S1162	08/11/2011
	the hospital failed	d to document annual			
	•	enance (PM) of 1 piece		Immediate Corrective Action:	
	*	uipment in accordance		Our PM checklist was	
		aipment in accordance		modified to match	

NAMIFOR PROVIDER OR SUPPLIES  KINDRED HOSPITAL INDIANAPOLIS  (INCITION WITH ST  REGULATORY OR LISE IDENTIFYING REFORMATION)  With the manufacturer's recommended maintenance schedule.  Findings:  1. Review of the manufacturer's recommended maintenance schedule for the air conditioning unit indicated the following Annual Maintenance:  - Check and tighten all setscrew, bolts, looking collars and sheaves.  - Visually inspect the entire unit casing for chips or corrosion and repair surfaces.  - Check superheat setting. It should be 12 to 17 F at the compressor.  - Inspect all waterside plugs for corrosion or leaks and replace if necessary.  2. Review of a document entitled AC unit, Annual [PM], indicated it did not include the above checks were not done and no other documentation was provided prior to exit.  SITREET ADDRESS, CITY, STATE, ZIPCODE  1700 W 10TH ST  INDIANAPOLIS.  STREET ADDRESS, CITY, STATE, ZIPCODE  1700 W 10TH ST  INDIANAPOLIS.  (X3)  PRIPTY  TAG  Manufacturers recommended maintenance schedule or present of the Americana commendations	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
INDIANAPOLIS (NATIONAL INDIANAPOLIS  (X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PEACEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  With the manufacturer's recommended maintenance schedule.  Findings:  1. Review of the manufacturer's recommended maintenance schedule for the air conditioning unit indicated the following Annual Maintenance:  - Check and tighten all setscrew, bolts, locking collars and sheaves.  - Visually inspect the entire unit casing for chips or corrosion and repair surfaces.  - Check superheat setting. It should be 12 to 17 F at the compressor.  - Inspect all waterside plugs for corrosion or leaks and replace if necessary.  2. Review of a document entitled AC unit, Annual [PM], indicated it did not include the above checks were not done and no other documentation was provided prior to			152007				07/13/2011
With the manufacturer's recommended maintenance schedule.  Findings:  1. Review of the manufacturer's recommended maintenance schedule.  Findings:  1. Review of the manufacturer's recommended maintenance schedule for the air conditioning unit indicated the following Annual Maintenance:  - Check and tighten all setscrew, bolts, locking collars and sheaves Visually inspect the entire unit casing for chips or corrosion. Remove rust or corrosion and repair surfaces Check superheat setting. It should be 12 to 17 F at the compressor Inspect all waterside plugs for corrosion or leaks and replace if necessary.  2. Review of a document entitled AC unit, Annual [PM], indicated it did not include the above checks.  3. On 7-13-11 at 2:05 pm, upon interview, employee #A2 indicated the above checks were not done and no other documentation was provided prior to				1700 W 10TH ST			
maintenance schedule.  Findings:  1. Review of the manufacturer's recommended maintenance schedule for the air conditioning unit indicated the following Annual Maintenance:  - Check and tighten all setscrew, bolts, locking collars and sheaves Visually inspect the entire unit easing for chips or corrosion. Remove rust or corrosion and repair surfaces Check superheat setting. It should be 12 to 17 F at the compressor Inspect all waterside plugs for corrosion or leaks and replace if necessary.  2. Review of a document entitled AC unit, Annual [PM], indicated it did not include the above checks.  3. On 7-13-11 at 2:05 pm, upon interview, employee #A2 indicated the above checks were not done and no other documentation was provided prior to	PREFIX	(EACH DEFICIEN REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
, i i i i i i i i i i i i i i i i i i i	TAG	with the manufact maintenance school maintenance school Findings:  1. Review of the recommended mather air conditioning following Annual - Check and tight locking collars at - Visually inspectings or corrosion and repair surficients - Check superheat to 17 F at the corroller all water or leaks and replained and repair surficients. Review of a dunit, Annual [PM include the above of the superheat	emanufacturer's aintenance schedule for ing unit indicated the I Maintenance:  ten all setscrew, bolts, and sheaves. It the entire unit casing for in. Remove rust or  faces. It setting. It should be 12 inpressor. It side plugs for corrosion ace if necessary.  cocument entitled AC indicated it did not be checks.  12:05 pm, upon yee #A2 indicated the re not done and no other		TAG	manufacturers recommendatio  Further Corrective Action to prevent Recurrence: The modified PM checklist will be utilized for all AC unit PM's going forward.  Monitoring: The Director of Plant Operations will ensure revised checklist is utilized for all AC unit PM's. The AC unit PM was redone utilizing the revised tool on 8/11/11. Any i identified will be corrected and reported through EOC, Quality Council, MEC and Governing Board.  Responsibility:	ns DATE  ns Ssues

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152007		(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	(X3) DATE COMP! 07/13/2	LETED		
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 W 10TH ST INDIANAPOLIS, IN46222				
	SUMMARY S (EACH DEFICIEN REGULATORY OR 410 IAC 15-1.5-8(  (d) The equipmen follows: (2) There shall be equipment and sp safe, effective, and of the available se as follows:  (B) There shall be preventive mainte equipment. Based on docum failed to provide maintenance (PN equipment.  Findings:  1. On 7-11-11 at #A2 was request documentation of machine and a C	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) d)(2)(B)  It requirements are as sufficient ace to assure the d timely provision ervices to patients, e evidence of nance on all ent review, the hospital evidence of preventive d) for 3 pieces of	I	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	Action: and as with a braned on CT bocuments  ction to quired to perations s so we can	(X5) COMPLETION DATE  08/11/2011	
				received timely.  Monitoring: The Director of Plant C will monitor PM due de Radiology staff will en Operations is aware whouse for PM's to ensu compliance. Any issues identified we corrected and reported through E	ates and the sure Plant nen vendor in-re		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152007	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 07/13/2011
	PROVIDER OR SUPPLIER  D HOSPITAL INDIA		1700 W	ADDRESS, CITY, STATE, ZIP CODE / 10TH ST IAPOLIS, IN46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
				Quality Council, MEC and Governing Board.	
				Responsibility: Director Plant Operations	